Welcome To
Kennesaw Pediatrics
Your Home for Pediatric Healthcare!

3745 Cherokee Street, Suite 401 - Kennesaw, GA 30144
770 - 429-1005 - Phone
770-429-8005

Authorization to Release Records

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT(S) NAME (S):

	DOB	
	DOB	
	DOB	
	DOB	

PATIENT(S) ADDRESS: ____

INFORMATION TO BE RELEASE:

____ IMMUNIZATIONS/GROWTH CHARTS ONLY

____ COMPLETE RECORD (There is a $15 administration fee charged for each child's record that has been requested for transfer. Payment is due prior to the delivery of such request.)

REASON FOR REQUEST:

____ Personal Records ____ Insurance ____ School ____ Legal
____ Requested by Specialist / Referral
Transferring Out:
Reason for Transfer: ___ Relocation ___ Change in insurance/coverage
___ Unhappy with Staff/Practice Other:____________________

DELIVERY OF RECORDS:

____ Pick up in person ____ Via regular mail ____ Fax (fax#)____________

RELEASE INFORMATION TO:

NAME: ____________________________________

ADDRESS:____________________________________

CITY: ________________ STATE: ________ ZIP:__________

PHONE: ________________ FAX:________________

*** By signing below, I understand that (1) I release Kennesaw Pediatrics and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damage, which may result from the release of information authorized by this Consent for Release of Medical Information; (2) This consent is valid from the date signed and continues until I revoke this authorization by giving Kennesaw Pediatrics written notice, (3) I may revoke this authorization at any time, unless the action has already been taken utilizing this signed consent or it the authorization was obtained as a condition of obtaining insurance coverage, (4) The practice will not condition treatment or payment based on my signing this authorization, (5) I am signing this authorization freely, (6) No one has pressured me to sign this authorization, (7) I acknowledge that I've had an opportunity to review this authorization and understand the intent and use, (8) The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.

Signature of Parent/Guardian: ______________________________ Date: ______________

Relationship to the patient: ______________________